EXHIBIT D

Leave of Absence
P.O. Box 17427
Clearwater, FL 33762
Fax: 1-800-310-7740
Ph: 1-800-234-MACY (6229)
Email: bloomingdales.loa@bloomingdales.com

6/9/2017

Kristina Mikhaylova
7330 198 St Apt 1
Fresh Meadows, NY 11366

Payroll # 72061886

Dear Kristina:

We have been notified that you are requesting a Leave of Absence for 04/23/2017 to (approximately) 11/21/2017. Enclosed you will find important information about your Leave of Absence and the documentation required in order for the Company to approve and/or continue your leave. It is important that you understand your responsibilities during your leave so please review this information carefully. If you have any questions regarding this information or what is requested, please contact us.

Important – If you have not provided a health care certification your leave will be pending and not approved. All information requested must be mailed or faxed to the HR Services Leave of Absence team to the address above. HR Services will administer your leave request. If you need assistance in completing the forms, or if there are circumstances that prevent you from meeting the deadlines, please call the HR Services Leave of Absence team at 1-800-234-MACY (6229) or your HR Manager as soon as possible. Remember to stay in contact with your HR Manager regarding the status of your leave.

Please complete the following forms, sign and return to HR SERVICES within 15 days.
If we do not receive this information from you within 15 days, your leave may be delayed or denied.

- Certification of Health Care Provider Needed
- Request for Leave of Absence Form Needed
- Notice of Eligibility and Rights & Responsibilities to Employee Request for Family Medical Leave (FMLA) Needed

Short Term Disability Benefit Information

[X] If you are enrolled in a Short Term Disability plan at Macy's and if your leave is approved, you may be eligible to file a claim for Bloomingdale's Short Term Disability Benefit. Please see "Your Benefits While on Leave", Short Term Disability Pay section. If you have any questions about your eligibility please call 1-800-234-MACY (6229).

Sincerely,

Demario J Rodriguez
HR Services Leave of Absence Team

Leave of Absence
P.O. Box 17427
Clearwater, FL 33762
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Email: bloomingdales.loa@bloomingdales.com

From: Kristina Mikhaylova
Payroll #: 72061886 Date:
Number of Pages Including Cover:
Comments:

HR Services Leave of Absence
Fax #: 1-800-310-7740

Please include this cover sheet with any information related to your leave of absence.

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

SECTION I: For completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Bloomingdale's HR Services Leave of Absence, 1-800-234-MACY (6229)

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: [ ]

SECTION II: For completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Kristina Mikhaylova

First Middle Last

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Further Instructions to the Healthcare Provider as added by the Company: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: ( ) _____ Fax: ( ) _____

CONTINUED ON NEXT PAGE

PART A: Medical Facts

1. Approximate date condition commenced:

   _____

   Probable duration of condition:

   _____

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   [ ] No [ ] Yes. If so, dates of admission:

   _____

   Date(s) you treated the patient for condition:

   _____

   Was medication, other than over-the-counter medication, prescribed? [ ] No [ ] Yes

   Will the patient need to have treatment visits at least twice per year due to the condition? [ ] No [ ] Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   [ ] No [ ] Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? [ ] No [ ] Yes. If so, expected delivery date:

   _____

   Leave may be available for either baby bonding or in the event of a serious health condition. Please indicate the amount of time off needed for each category:

   Baby bonding _____

   Serious Health Condition _____

   If this information changes during the leave, please provide updated medical certification.

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition? [ ] No [ ] Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? [ ] No [ ] Yes

   If so, estimate the beginning and ending dates for the period of incapacity:
   _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? [ ] No [ ] Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? [ ] No [ ] Yes

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hours per day _____ days per week from _____ to _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? [ ] No [ ] Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? [ ] No Yes
   If so, explain: _____

   _____

   _____
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or _____ days per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

CONTINUED ON NEXT PAGE

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

Kristina Mikhaylova Payroll # 72061886 Store #72001

REQUEST FOR LEAVE OF ABSENCE

- You may fax completed forms to HR Services 1-800-310-7740
- If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

Date Leave to Begin: _____(Approximate) Date Leave to End: _____

I request that I be granted an:

¨ ***Original Leave of Absence***

¨ ***Extension to my Leave of Absence***

I am requesting my leave for the following reason:

¨ To care for my newborn, or the placement of a child with me for adoption or foster care;
¨ A serious health condition that prevents me from performing an essential function of my job
¨ A serious health condition for which I need to provide care for:
___my spouse ___domestic partner (as defined by Company policy)
___child ___parent
¨ My disability due to pregnancy or pregnancy related conditions.
¨ To care for a qualified ill/injured military service member (FMLA)
¨ Military Exigency leave (FMLA)
¨ Unpaid leave when spouse is on leave from qualified military deployment
¨ Military leave (USERRA)
¨ Other: please explain_____

Complete only if requesting leave on an intermittent basis:

Intermittent/Reduced hour schedule leave Proposed Schedule

Reason for change in schedule-

I understand that:

1. If I am granted the leave of absence requested above, I am expected to return to work on or before the date indicated above that my leave is to end. If I cannot return to work on this date, I must request an extension of my leave from my HR Services and Human Resources Manager. I agree to submit any additional supporting medical certification or documents requested by my Human Resource Manager and/or HR Services to support my leave of absence and/or any extension.
2. I will remain an employee of the Company while on an approved leave of absence unless my position is eliminated as a result of business needs.
3. I may not take a leave for the purpose of seeking, accepting or working at another place of employment. I may not accept employment, or be self-employed, if it is inconsistent with the restrictions provided by my Health Care Provider. Such actions while on a FMLA leave, or any other authorized leave, may be subject to discipline up to and including termination.
4. Insurance premiums that I am responsible for will be deducted automatically from any disability pay or salary continuation benefits I am entitled to receive. I must directly pay any premiums not collected via payroll deductions, to Bloomingdale's. Failure to pay any insurance premiums due may result in my loss of insurance coverage.
5. For certain leaves, I may be required to exhaust all applicable paid time off first. This may include PTO, holidays, or any other paid leave available to me. Please refer to the paid time off policy for accrual while on leave of absence.
6. I must contact my Human Resource Manager and HR Services at least 2 weeks prior if possible and no later than 2 (two) business days prior to the date indicated as my return to work date. Failure to do so may result in a delay in my return to work.
7. It is my obligation to notify HR Services of any change of address during my leave.

Employee Signature: Date:

What Next?

You may fax completed forms to 1-800-310-7740 or bloomingdales.loa@bloomingdales.com. If you need assistance completing the forms, please contact your Human Resource Manager or HR Services at 1-800-234-6229(MACY).

Kristina Mikhaylova Payroll # 72061886 Store #72001

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181 Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[PART A – NOTICE OF ELIGIBILITY]

To: Kristina Mikhaylova

From: HR Services – Leave of Absence

Date: 6/9/2017

On 06/08/2017 you informed us that you needed leave beginning on 04/23/2017 for:

[] The birth of a child, or placement of a child with you for adoption or foster care;

[X] Your own serious health condition;

[] Because you are needed to care for your [ ] spouse; [ ] child; [ ] parent due to his/her serious health condition.

[] Because of a qualifying exigency arising out of the fact that your [ ] spouse; [ ] son or daughter; [ ] parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.

[] Because you are the [ ] spouse; [ ] son or daughter; [ ] parent; [ ] next of kin of a covered service member with a serious injury or illness.

This notice is to inform you that you:

[X] Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

[ ] Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

[ ] You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately months towards this requirement.

[ ] You have not met the FMLA's 1,250-hours-worked requirement.

[ ] You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact HR Services at 1-800-234-MACY or view the FMLA poster located in your store HR location.

Kristina Mikhaylova Payroll # 72061886 Store #72001

[PART B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by 6/24/2017. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

[X] Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request [X] is/ [ ] is not enclosed.

[ ] Sufficient documentation to establish the required relationship between you and your family member.

[ ] Other information needed: _____

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

[x] If you are enrolled in benefits contact HR Services/Benefits at 1-800-234-6229(MACY) to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

[ ] You will be required to use your available paid [ ] accrued PTO, and/or [ ] other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

[ ] Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We [ ] have/ [ ] have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

[x] While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every 30 days. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave changes and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:
You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

[ ] the calendar year (January – December).

[ ] a fixed leave year based on _____.

[ ] the 12-month period measured forward from the date of your first FMLA leave usage.

[x] a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

Kristina Mikhaylova Payroll # 72061886 Store #72001

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member with a serious injury or illness. This single 12-month period commenced on

- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.

- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)

- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered service member's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

- if we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have [ ] accrued sick days, [x] accrued PTO (as applicable) and/or [x] other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

[x] For a copy of conditions applicable to sick days/PTO/other leave usage please refer to the information under your benefits while on leave and/or the company PTO policy.

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

1-800-234-MACY (6229)

I acknowledge that when I notified the Company of my need for Family Medical Leave Act, the Company provided me with notice of my rights and obligations and answered any questions I had presented.

_____ _____

Date Signature of Employee

This form will need to be mailed to:

Leave of Absence
P.O. Box 17427
Clearwater, FL 33762-0427